Summerside
Naturopathic

Dr. Linda Morrison B.Sc. ND
337 Central St. Holistic Health Centre
Summerside, PE
(902) 724-3334

PLEASE COMPLETE THIS FORM AND RETURN IT TO
DR. MORRISON AT YOUR FIRST VISIT.

Adult Intake

(please print clearly)

Name ____ Date _________________

Date of birth __________________________ (M/D/Y) Sex M F

Address:____

____

____

____

E-mailAddress:____

Telephone number: Home:______________________ Cell:________________________

May we leave messages relating to your visits? Y / N Work: ______________________

Emergency contact: Name: ____

Phone number:___________________ Relation:_____________________________

How did you hear about our Clinic:____

Other health care providers you are seeing: (Name, Address, Phone)

1. ______________________ 2. ______________________ 3. ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

(_____)________________ (_____)________________ (_____)________________

What are your health concerns, in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

____
____
____
____
____
____
____

Do you have any allergies (medicines, environmental, etc.)?

____
____
____
____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

____
____
____
____

Please list past prescription medications.

____
____
____
____
____
____

How many times have you been treated with antibiotics? For what?

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections
Alcohol—how much/day or week ____
Tobacco—form and amount/day ____
Caffeine—form and amount/day____
Recreational drugs—what and how often_______________________________________

Please indicate what immunizations you have had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? __________________________	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

☐ Swine flu
☐ Gardasil

☐ Standard Childhood vaccinations

Please indicate if any caused adverse reactions:

____
____

Do you get regular screening tests done by another doctor? (Pap, breast, colon, blood tests, etc.)?
Y / N

Diet

Do you have any food allergies or intolerances? Please list.

____
____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____
____
____
____

Describe a typical day's diet:

Breakfast ____

Lunch____

Dinner____

Snacks____

Beverages (and total quantity) ______________________________

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

Occupation ____

Hobbies ____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____
____
____
____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Is there anything that you feel is important that has not been covered?

For file use only.